COUNTY MEDICAL SERVICES
STATEMENT OF MEDICAL NECESSITY
REQUEST FOR SLEEP APNEA STUDY

Patient Name _____ **SSN** _____

Date _____ **CMS Eligible From:** _____ **To:** _____

Clinic _____ **Requesting Practitioner** _____

Please complete the information below to determine the medical necessity of a Sleep Apnea Study.

Patient History of Sleep Disturbance

Average number of hours of sleep each night _____

Does patient nap during the day? ☐ Occasionally ☐ Daily

Snoring: Soft ☐ Loud ☐

☐ Falls asleep while driving ☐ Excessive daytime somnolence

☐ Wakens with a sensation of choking or gasping

Medical Conditions

☐ Hypertension
☐Controlled ☐Malignant

☐ Depression

☐ Diabetes ☐Type I ☐Type II
Controlled ☐Yes ☐No

☐ Allergic Rhinitis

☐ Asthma

☐ Nocturia

☐ Obesity

☐ Heart Disease

Life Style Behaviors

Number of caffeinated beverages per day _____

Amount of alcohol consumed ☐ Daily _____ ☐ Occasionally _____

Smokes more than 1 pack of tobacco per day ☐ Yes ☐ No

Does the patient have a stable home environment? ☐ Yes ☐ No

Medical Exam (all required)

Height _____ Weight _____ Blood Pressure _____ Neck circumference _____

Adeno-tonsillar enlargement ☐ Yes ☐ No

Maxillo-mandibular malformation ☐ Yes ☐ No

Medications (list all)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The practitioner has discussed the treatment options with the patient ☐ Yes ☐ No

If a CPAP is indicated, the patient is willing to tolerate the inconvenience of the treatment (equipment, noise, dryness). ☐ Yes ☐ No